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Workplan for the USAID ZdravReform Program in Central Asia June 1998 to June 2000

I. Introduction

A. Background

The USAID ZdravReform Program has been operational in Central Asia since June 1994, when the regional office in Almaty was established. During the last four years it has developed a strong program in Kazakhstan and Kyrgyzstan, and in 1997 a program was initiated in Uzbekistan. The principal program strategy has been to develop comprehensive, integrated demonstrations in selected oblasts in all three countries to reform both the health service delivery system and health financing and to work at the national level to create the legal framework and public awareness to support the reforms. Appendix A provides additional background and outlines the model for the ZdravReform Program.

In September 1996, an evaluation was carried out of USAID's ZdravReform Program in Central Asia, Russia, and the Ukraine. The evaluation found that "the project is making a major contribution to the achievement of Central Asia's and ENI's strategic objectives" and that "the project is meeting or exceeding the targets outlined in the annual workplans."

One of the principal findings was support for "the rolling design" of the project. As the report explains, "because of site-specific problem analysis and the ability to tailor the design of local project interventions, the intensive demonstration sites have been able to target the issues most relevant to the reform of the financing system and the organization of health care delivery." The evaluation suggested that it is important to design the project option with sufficient flexibility to change activities based on the commitment to reform.

Following the merger of two oblasts in which USAID's ZdravReform Program was operating into other oblasts in May 1997, it was agreed that it would be productive to sign a Memorandum of Understanding (MOU) with the Government of each country in order to protect health reform activities in the event of such unforeseen events. Detailed MOUs were drafted, discussed with the relevant Government authorities, and subsequently signed in 1997. These MOUs now provide a valuable framework for USAID's ZdravReform Program activities.

B. Staffing

During this two year option period the staffing and office strategy developed over the last four years will be continued. The Regional Office in Almaty will continue to serve as the administrative and technical center for program activities in Central Asia. Offices in the capital cities of Bishkek, Tashkent, and of course Almaty, will be responsible for coordination of all activities within the country. Demonstration offices

such as Karakol, Kyrgyzstan; and Fergana, Uzbekistan will be responsible for coordinating all health reform activities within the demonstration site.

In addition to the expatriate staff there will continue to be a strong contingent of local staff. Local staff are essential to the success of the project as they have assumed many technical and administrative functions over the last four years. Additional local staff may be hired as necessary for evolving program activities.

The contingent of "long-term, short-term" consultants will remain relatively stable. In some cases, there will be a need to draw on specialized expertise currently not available. In these cases, additional short-term international consultants will be recruited. As the reforms mature, there is a greater need for highly specialized technical expertise. This type of expertise is available from the U.S. Health Care Financing Administration (HCFA) and the Agency for Health Care Policy and Research (ACHPR). An inter-agency agreement with HCFA and ACHPR would provide access to this highly specialized technical expertise.

One of the sub-contractors of the ZdravReform Program is the International Executive Service Core (IESC). They provide retired executives which function as consultants for only expenses, normally for a six week period. An early ZdravReform Program experience with IESC was only marginally beneficial, however, the reforms have matured and the environment is more conducive to the type of management expertise provided by IESC. The ZdravReform Program may attempt to recruit IESC personnel for targeted, narrowly defined tasks. Finally, noting the cost-effectiveness of locally recruited expatriate consultants, the program may use such people to meet certain relevant specific needs which may arise.

As the project has matured, the role of headquarters has changed. Under the new contract Abt/Bethesda will no longer continue to play a key role in contracting, finance, oversight, and technical direction. The contracting and finance functions will move out to the field and be managed by the new position of Finance/Contracts Deputy Director. This is in-keeping with USAID’s decision to move the COTR and Contracting Officer out to the field. Oversight and backstopping support in Bethesda will thus be reduced to consist of one FTE, a Program Coordinator.

The USAID ZdravReform Program proposes three key staff positions, all of which are regional positions:

1. Director
2. Technical Deputy Director
3. Finance/Contracts Deputy Director

For the position of Director, the USAID ZdravReform Program proposes Co-Directors, Michael Borowitz and Sheila O'Dougherty. Currently, Michael Borowitz is the Director and Sheila O'Dougherty is the Deputy Director. They have both been with the program since its inception. As the program is broad, spread across Central Asia, and requires significant travel from the regional offices, Michael Borowitz and Sheila O'Dougherty currently effectively function as Co-Directors. Establishing Co-Directors is just formalizing the way the program has been operating for the last three years.

For the position of Technical Deputy Director, the USAID ZdravReform Program proposes Cheryl Wickham. Cheryl has been with the program for 2 1/2 years. She is a health economist capable of addressing all technical issues.

For the position of Finance/Contracts Deputy Director, the USAID ZdravReform Program proposes David Miller. Upon learning of the shift of the COTR and contracting functions from Washington to Central Asia, the program recruited David for the express purpose of filling this position, which also includes administrative functions. He will be posted to Central Asia in June, 1998.

The staffing chart will continue to be refined as program requirements evolve. It is a priority of the ZdravReform Program to ensure that sufficient technical human resources are in place. At this point, expatriate staff, expatriate international consultants, expatriate local consultants, and local staff are sufficient for program needs. If program needs require and financial resources allow, additional technical expatriate staff will be recruited.

C. Reporting

Over the past four years, USAID's ZdravReform Program has prepared regular reports providing USAID/CAR and USAID/Washington with financial and program activity reports. During the two year option period monthly financial and program activity reports will continue to be prepared and submitted to the COTR in Almaty. In addition, a bi-annual report will be submitted to measure program achievements against the results framework. A travel and leave schedule will be provided on a monthly basis in order to obtain the necessary country clearances. Finally, other technical reports will be prepared as needed.

II. ZdravReform Program Workplan

A. Scope of Work (SOW)

This workplan responds to a SOW submitted by the COTR for the CAR USAID ZdravReform Program two year option period. The SOW stated that the main focus of the program activities in the option period is to provide technical assistance and training to complete and deepen the ongoing reforms in the pilot sites and expand the reforms to other regions and areas of the respective countries. Specifically, the contractor is responsible to achieve the results stated in SO 3.2 "Improved sustainability of selected social services."

The SOW stated that to achieve the above mentioned result, the contractor will:

1. Provide technical assistance, training, grant support and limited equipment, books and supplies to effectively implement the program stated in the Memorandum of Understanding that USAID has signed with Kyrgyzstan, Kazakhstan and Uzbekistan;
2. Provide technical assistance, training to increase public awareness and education regarding health reform and health issues, and disseminate results through media, journals, books and other appropriate communication vehicles;

3. Provide technical assistance, training and grants support, equipment and supplies, as requested by USAID/CAR and as opportunities arise in Turkmenistan and Tajikistan;
4. Collaborate with the World Bank and other donors to assist with the roll out of health reform to additional regions, as agreed upon, with USAID/CAR;
5. Provide technical assistance, training, grants support, equipment and supplies needed to enhance the effectiveness of integrated services. Collaborate with other USAID implementing partners to effectively integrate appropriate programs such as family planning and infectious disease activities within the primary health care framework;
6. Collaborate with the health partnerships program to maximize impact of USAID technical assistance in the respective countries;
7. Coordinate activities with other parts of the health reform initiative in the NIS to enhance program effectiveness;
8. Strengthen policy dialogue and provide technical assistance and training in the area of legal and regulatory work to ensure that health sector reforms are adopted nationally and are sustainable;
9. Provide technical assistance, training, grants, equipment and supplies to improve management of scarce resources throughout the health sector;
10. Prepare case studies and lessons learned related to reforms, planning integration for dissemination regionally and in the NIS.

B. Program Parameter -- Geography

One of two program parameters defining the USAID ZdravReform Program is geography. Historically, the ZdravReform Program has been defined by two levels of geography, with the first geographic level being the five different countries of Central Asia and the second geographic level being the demonstration sites contractually and programmatically required within each country.

Over the next two years, this parameter, geography, will continue to be used to define the ZdravReform Program. The geographic sites by country are as follows:

1. Kazakhstan

1.1 National Level

Almaty has been the geographic site for national level work over the last 3 1/2 years. National level work will continue in Almaty over the two year option period. Currently, it is unclear how much of the national level work will need to be done in the new capital of Astana. This uncertainty constitutes a mitigating factor for both workplan activities and budget.

1.2 Zhezkazgan and Satpaeva Cities

Although the former Zhezkazgan Oblast merged into Karaganda Oblast in May 1997, it is still a geographic site now defined as Zhezkazgan City and it's sister city Satpaeva City. Program activities are defined by a workplan signed by the Karaganda Akim, the National Committee on Health (COH), the National Mandatory Health Insurance (MHI) Fund, and USAID, as well as the Kazakhstan Memorandum of Understanding between

the US Government and the Government of Kazakhstan (MOU). Work is implemented through the City Governments, City Health Departments, and the Regional MHI Fund.

1.3 Karaganda Oblast

After the merger of the former Zhezkazgan Oblast into Karaganda Oblast, discussions with Karaganda Oblast officials and national officials resulted in a formal agreement and workplan to continue work in Zhezkazgan City and Satpeva City and informal agreement to begin the process of rolling-out the health reforms from Zhezkazgan to Karaganda. Therefore, Karaganda Oblast will become a new geographic site for the next two years with a workplan being used to determine activities.

1.4 Semipalatinsk Region

Although the former Semipalatinsk Oblast merged into East Kazakhstan Oblast in May 1997, it is still a geographic site. Program activities are defined by a workplan signed by the East Kazakhstan Akim, the National COH, the National MHI Fund, and USAID, as well as the Kazakhstan MOU. The workplan defines the former Semipalatinsk Oblast as the "Western Region of East Kazakhstan Health Reform Experiment Site", although it is referred to in the workplan as Semipalatinsk for the sake of convenience and continuity. Work is implemented through the City Governments, City Health Departments, and the Regional MHI Fund. In addition, work in Semipalatinsk will continue as part of an agreement between USAID and the World Bank to provide technical assistance to the geographic sites of the World Bank Health Reform Project.

In the USAID ZdravReform Program workplan, Semipalatinsk is separated into two sites, Semipalatinsk rural and Semipalatinsk urban. This is because the two sites are at different levels of development, Semipalatinsk rural is a mature geographic site and Semipalatinsk urban is a start-up geographic site.

1.5 East Kazakhstan Oblast

East Kazakhstan will be a new geographic site over the next two years as USAID rolls out the Semipalatinsk reforms to East Kazakhstan and provides technical assistance to the geographic sites of the World Bank Health Reform Project.

1.6 Almaty Oblast/Almaty City

Almaty Oblast will be a new site for geographic site over the next two years as USAID provides technical assistance to the geographic sites of the World Bank Health Reform Project. Work in Almaty Oblast will not commence until 1999.

Work in Almaty City, other than the national level, began in 1997 in two polyclinics. It will continue over the next two years, although very limited in scope.

1.7 Pavlodar Oblast

Pavlodar Oblast will not be a full-blown geographic site, however, limited assessment and training activities will be undertaken.

2. Kyrgyzstan

2.1 National Level

The national level in Bishkek became a geographic site in 1997 and will continue over the next two years. National level activities include not only national legal and policy

framework but also activities such as new provider payment systems normally implemented at the oblast level. In effect, the entire country of Kyrgyzstan has become a demonstration site. National level activities will also include limited work in Naryn and Talas Oblasts, the only oblasts in Kyrgyzstan not yet covered by health reform.

2.2 Issyk-Kul Oblast

Issyk-Kul Oblast will continue as a geographic site as the existing reforms are widened and deepened for sustainability. In addition, it serves as a base for the roll-out of health reforms throughout Kyrgyzstan. The workplan continues health reform in Issyk-Kul through 1999 and then begins shut-down in 2000.

2.3 Osh Oblast

Osh Oblast will be a new geographic site over the next two years. Start-up activities in Osh Oblast began in January, 1998 with the approval of a USAID proposal by the Ministry of Health (MOH). Programmatic activities will begin in May or June, 1998. The USAID ZdravReform Program will collaborate with an Asian Development Bank Social Sector/Local Government Project expected to begin early in 1999 in Osh Oblast.

While the work in Osh Oblast rolls-out the Issyk-Kul Oblast demonstration, there was an intermediate step. Over the last year, the program concentrated on developing the health reform framework at the national level. Therefore, the health reforms will be extended to South Kyrgyzstan based on this national health reform framework.

2.4 Jalal-Abad Oblast

Jalal-Abad Oblast will be a new geographic site over the next two years. Start-up activities in Jalal-Abad Oblast began in January, 1998 with the approval of a USAID proposal by the Ministry of Health (MOH). Programmatic activities will begin in May or June, 1998. The USAID ZdravReform Program will collaborate with an Asian Development Bank Social Sector/Local Government Project expected to begin early in 1999 in Jalal-Abad Oblast.

While the work in Jalal-Abad Oblast rolls-out the Issyk-Kul Oblast demonstration, there was an intermediate step. Over the last year, the program concentrated on developing the health reform framework at the national level. Therefore, the health reforms will be extended to Jalal-Abad Oblast based on this national health reform framework.

2.5 Bishkek City

In 1997, A World Bank Health Sector Reform Project began to roll-out the Issyk-Kul demonstration to Bishkek City. Over the next two years, the USAID ZdravReform Program will collaborate and coordinate with the World Bank Project and provide technical assistance and training to facilitate this roll-out.

2.6 Chui Oblast

In 1997, A World Bank Health Sector Reform Project began to roll-out the Issyk-Kul demonstration to Chui Oblast, the oblast surrounding Bishkek City. Over the next two years, the USAID ZdravReform Program will collaborate and coordinate with the World Bank Project and provide technical assistance and training to facilitate this roll-out.

3. Uzbekistan

3.1 National Level

Tashkent is the geographic site for national level activities and this work will continue over the next two years. Start-up began in the fall of 1997, following the completion of the World Bank Health Reform Project design process.

3.2 Fergana Oblast

Start-up in the geographic site of Fergana Oblast began in the winter of 1998 and work will continue over the next two years. Programmatic activities were initiated in the spring of 1998. Fergana Oblast was selected as a geographic site because USAID desired to provide technical assistance to the geographic sites of the World Bank Health Reform Project. Fergana Oblast was chosen as the lead demonstration oblast in Uzbekistan after consideration of a number of factors, including geography and the health reform environment.

3.3 Navoi Oblast

Start-up in the geographic site of Navoi Oblast is projected to begin in the summer of 1999. Navoi Oblast was selected as a geographic site because USAID desired to provide technical assistance to the geographic sites of the World Bank Health Reform Project. As program activities in Navoi Oblast will be rolled-out from Fergana Oblast, work in Navoi Oblast will not begin until reforms in Fergana Oblast have progressed satisfactorily, although some participants from Navoi Oblast may be included in training activities.

3.4 Syr Darya Oblast

Start-up in the geographic site of Syr Darya Oblast is projected to begin in the summer of 1999. Syr Darya Oblast was selected as a geographic site because USAID desired to provide technical assistance to the geographic sites of the World Bank Health Reform Project. As program activities in Syr Darya will be roll-out from Fergana Oblast, work in Syr Darya Oblast will not begin until reforms in Fergana Oblast have progressed satisfactorily, although some participants from Syr Darya Oblast may be included in training activities.

4. Turkmenistan

At this point no work sites are planned in Turkmenistan. However, some participants from Turkmenistan may be invited to conferences or other types of training. Assessment in collaboration with other donors will continue, potentially resulting in program activities as funds become available.

5. Tajikistan

At this point no work sites are planned in Tajikistan. However, some participants from Tajikistan may be invited to conferences or other types of training. Assessment in collaboration with other donors will continue, potentially resulting in program activities as funds become available.

C. Program Parameter -- USAID Results Framework

Beginning in 1995, the ZdravReform Program was defined by a new parameter, the USAID Results Framework for Strategic Objective 3.2 - Improved sustainability of social services. Over the last two years, ZdravReform Program activities have been planned and implemented in accordance with the USAID Results Framework. In other words, all program activities are designed to target various elements of the USAID Results Framework. This framework is incorporated throughout program management -- the workplan, budget allocations and reporting all flow from the USAID Results Framework.

The ZdravReform Program is responsible for two Intermediate Results which directly contribute to the Mission's broader Strategic Objective (SO) 3.2. These two Intermediate Results are IR 3.2.1 -- Cost-effective health services demonstrated in selected oblasts and IR 3.2.3 -- Cost-effective health sector reforms adopted nationally.

In addition to the Intermediate Results, the USAID Results Framework contains Lower Level Results (LLR) which contribute to achieving the Intermediate Results. These LLR are called elements in the workplan which follows. The numbering system is consistent with Kyrgyzstan and Uzbekistan. Kazakhstan has a different numbering system due to an additional LLR, shift from public to private delivery of pharmaceuticals. This LLR is not included in the workplan as it is completed. For purposes of consistency in the workplan, Kazakhstan also uses the Kyrgyzstan and Uzbekistan numbering system.

The ZdravReform Program workplan matches the USAID Results Framework exactly with one exception. LLR 3.2.1.3 -- Monitoring system for health reforms established is not described separately, but rather is incorporated as an activity under all the other LLRs.

Over the next two years, this parameter, the USAID Results Framework, will continue to be used to define the ZdravReform Program. The ZdravReform Program workplan is based on the USAID Results Framework dated January 23, 1998 for Kazakhstan, Kyrgyzstan, and Uzbekistan.

The following table shows a matrix of the USAID ZdravReform Program parameters, USAID Results Framework and geography. The IRs and LLRs match the USAID Results Framework. The USAID Results Framework has been converted into a ZdravReform Program Results Framework. The only difference between these two frameworks is that many of the results in the ZdravReform Results Framework contain two levels. The reason for this is that the different geographic sites are at different stages of development, either start-up sites or mature sites. As the type of activities and cost structure vary across start-up and mature sites, it is necessary to differentiate them in order to plan and implement program activities, and facilitate accurate measurement of results.

In general, activities in start-up geographic sites widen health reforms and activities in mature geographic sites deepen health reforms for sustainability. The term "establish" is used for start-up sites and "strengthen" is used for mature sites. During the two year

option period, some of the geographic sites may graduate from start-up sites to mature sites with the resulting change in type of programmatic activities.

It is important to state explicitly a point contained implicitly in the ZdravReform Program Results Framework. The strength of the ZdravReform Program is that the health reforms are both comprehensive and integrated. Consistent with this, program activities funded by both USAID health reform monies and earmark monies for family planning and infectious diseases are incorporated into the same USAID Results Framework. Program activities covered by earmark monies for family planning and infectious diseases include: 1.) integrating family planning and infectious diseases into new primary care practices through technical assistance, training, materials, and equipment; 2.) improved monitoring of family planning and infectious diseases through management information systems; and, 3.) actively promoting better family planning and infectious disease knowledge by the population and clinical practices by health professionals.

D. USAID ZdravReform Program Workplan

The workplan which follows is based on the program parameter matrix described above. There are two intermediate results which contribute to achieving SO 3.2, IR 3.2.1 -- Cost-effective health services demonstrated in selected oblasts and IR 3.2.3 -- Cost-effective health sector reforms adopted nationally. Lower level results are described in the workplan as elements which contribute to achieving these intermediate results (termed results in the workplan). These elements vary by whether the geographic sites are start-up sites or mature sites. The program activities listed under each element are a standard set of activities required to achieve each element and the aggregated result. While the basic health reform model is the same in each geographic site, the environments vary, and, therefore, the standard set of activities may also vary slightly across geographic site.

IR 3.2.1 Cost-effective health care services demonstrated in selected oblasts

Cost-effective health care services demonstrated in selected oblasts is one of two USAID ZdravReform Program results. In general, this result consists of comprehensive, integrated demonstrations incorporating some mixture of the following elements.

LLR 3.2.1.5 Strengthened primary health care

The health care delivery system is an inverted pyramid with over 70 percent of health sector resources going to hospitals. Primary health care is weak both in terms of health care delivery system structure and clinical capability. The element strengthened primary health care contributes to the result cost-effective health care services demonstrated in selected oblasts by restructuring the primary health care delivery system, increasing the clinical capabilities of primary care health professionals, and integrating family planning and infectious diseases into primary health care. The ZdravReform Program will establish primary care practices (PCPs) in start-up geographic sites to widen the health reforms, and strengthen PCPs in mature geographic sites to deepen the health reforms for sustainability.

Establish Primary Care Practices

The geographic sites for establish PCPs are Semipalatinsk Urban, East Kazakhstan, Almaty, and Karaganda in Kazakhstan; Osh, Jalal-Abad, Bishkek City, and Chui in Kyrgyzstan; and Fergana, Navoi, and Syr Darya in Uzbekistan. In addition to establishing PCPs, work will include initial activities to integrate family planning and infectious diseases into primary health care. A summary for establish PCPs in these geographic sites is contained in the following table:

Country	Site	Initiate Timeframe	Roll-Out From	Collaborate	Graduate to Mature by June 2000
KAZ	Semi Urban	Year One	Semi Rural	World Bank	No
	East Kaz	Late Year One	Semi Rural	World Bank	No
	Almaty	Year Two	Semi Rural	World Bank	No
	Karaganda	Year Two	Zhezkazgan	None	No
KYR	Osh	Late Year One	Issyk-Kul	ADB	No
	Jalal-Abad	Late Year One	Issyk-Kul	ADB	No
	Bishkek City	Year One	Issyk-Kul	World Bank	No
	Chui	Year One	Issyk-Kul	World Bank	No
UZB	Fergana	Year One	New Uzb Model	World Bank	Yes
	Navoi	Year Two	Fergana	World Bank	No
	Syr Darya	Year Two	Fergana	World Bank	No

ZdravReform Program activities will consist of all activities necessary to establish PCPs, including the following:

1. Data collection and analysis of existing primary care system.
2. Formation and participation in Joint Working Groups.
3. Policy dialogue with national and oblast level health policy-makers.
4. Development of concept and policy framework.
5. Research existing laws and regulations.
6. Draft, develop, provide input to, or comment on new legal framework.
7. Develop, provide input to, or comment on operational implementation plans.
8. Provide training for all stakeholders through conferences, seminars, workshops, and meetings on health reform in general and the need to restructure primary health care in particular.
9. Provide or facilitate study tours and exchanges to the U.S., other countries, other parts of the region, or other demonstration sites concerning primary health care.
10. Disseminate existing reports or products on primary health care from mature demonstration sites to new demonstration sites.
11. On all aspects of establish PCPs, collaborate with other donors or projects to provide technical assistance, training, commodities, or humanitarian assistance for the development of primary health care.
12. Determine the roles and relationships between the PCPs and NGOs such as PCP Associations, and coordinate efforts to develop primary health care.
13. Develop lists of all existing primary care physicians.
14. Provide input to determination of new PCP locations and staffing patterns, and assist in formation of PCPs.
15. Assess clinical training capability, determine organizational structure for clinical training, including whether training practices are needed, assess or develop clinical

training curriculum, coordinate clinical training with existing medical education structure.
16. Develop organizational structure required to provide clinical training.
17. Provide initial round of clinical training to PCP physicians, nurses, and other health personnel.
18. Assess and inventory equipment and reference materials in existing primary care structure.
19. Develop lists of equipment and reference materials required for new PCPs.
20. Provide equipment and reference materials through grants or facilitate provision by other donors.
21. Research and document physical infrastructure of existing primary care structure.
22. Develop plans for creating or converting physical infrastructure to PCPs, create architectural drawings and renovation cost estimates for renovation of new PCPs.
23. Provide basic renovations or facilitate provision by other donors.
24. In concert with other donors or projects, do an initial assessment, develop an initial concept and plans, and do initial training and provision of materials or equipment for integration of family planning and women's reproductive health into PCPs.
25. In concert with other donors or projects, do an initial assessment, develop an initial concept and plans, and do initial training and provision of materials or equipment for integration of infectious diseases into PCP's. Infectious diseases targeted may include ARI/CDD, STDs, and TB (in partnership with CDC and Project HOPE). If appropriate for the environment, IMCI may be adapted in collaboration with WHO.
26. Do initial assessment of potential to expand PCP scope of services.
27. Coordinate with the national health promotion program to support the development of primary health care through prevention and increasing public awareness and health professionals capabilities in targeted clinical areas.
28. Develop and implement a monitoring and evaluation system.

Strengthen Primary Care Practices

The geographic sites for strengthen PCPs are Zhezkazgan and Satpaeva Cities, and Semipalatinsk Rural in Kazakhstan; and Issyk-Kul in Kyrgyzstan. In addition, Fergana in Uzbekistan will graduate from a start-up site to a mature site in year two. This means that each country will have at least one mature site for primary health care to serve as a model for sustainability in the future.

ZdravReform Program activities will consist of all activities necessary to strengthen PCPs, including the following:

1. Assess delivery of basic primary health care services provided by newly established PCPs.
2. Maintain policy dialogue and participation in Joint Working Groups.
3. Assess legal framework after formation of PCPs, draft, develop, provide input to, or comment on legal framework allowing institutionalization of PCPs and expansion of their scope of services.
4. Develop operational implementation plans for strengthen PCPs.
5. Provide additional training for all stakeholders through conferences, seminars, workshops, and meetings on health reform in general and the role of the new primary health care structure in particular.

6. Provide or facilitate study tours and exchanges to the U.S., other countries, other parts of the region, or other demonstration sites concerning primary health care.
7. On all aspects of strengthen PCPs, collaborate with other donors or projects to provide technical assistance, training, commodities, or humanitarian assistance for the development of primary health care and integration of family planning and infectious diseases into primary health care.
8. Strengthen the roles and relationships between the PCPs and NGOs such as PCP Associations and coordinate efforts to develop primary health care.
9. Provide clinical training to PCP physicians, nurses, and other health personnel to strengthen their clinical capability.
10. As capability of PCPs increases, inventory existing equipment and reference materials, facilitate reallocation of equipment from other health providers, and provide equipment and reference materials through grants or facilitate provision by other donors or humanitarian assistance.
11. As capability of PCPs increases, assess PCP physical infrastructure, train PCPs on the appropriate lay-out of PCPs, draft a guidebook on floor plans and renovations, create architectural drawings and renovation cost estimates, and provide additional renovations or facilitate provision by other donors.
12. Collect and analyze data to assess capability of PCPs to expand their scope of services in family planning, infectious diseases, laboratory services, and other ancillary services, develop and disseminate recommendations for expanded scope of services, provide training on expansion of services.
13. Develop policies and provide training for laboratory services provided by PCPs, develop equipment list for basic laboratory services, provide laboratory equipment through grants or facilitate provision by other donors.
14. In concert with other donors or projects, provide technical assistance, training, materials, and equipment for integration of family planning and women's reproductive health into PCPs.
15. In concert with other donors or projects, provide technical assistance, training, materials, and equipment for integration of infectious diseases into PCPs. Infectious diseases targeted may include ARI/CDD, STDs, and TB (in partnership with CDC and Project HOPE). If appropriate for the environment, IMCI may be adapted in collaboration with WHO.
16. Coordinate with the national health promotion program to support the development of primary health care through prevention and increasing public awareness and health professionals capabilities in targeted clinical areas.
17. Develop reports, products, and training materials on primary health care to facilitate information dissemination on primary health care.
18. Maintain and strengthen a monitoring and evaluation system.

LLR 3.2.1.4 NGOs facilitate implementation of health sector reform

The element NGOs facilitate implementation of health sector reform contributes to the result cost-effective health care services demonstrated in selected oblasts by facilitating the development of civil society and assisting in the implementation of health reforms. The NGOs established and strengthened will help stakeholders implement reform, provide services to members, and provide a representative voice within the health sector. The ZdravReform Program will establish NGOs in start-up geographic sites to widen the health reforms, and strengthen NGOs in mature geographic sites to deepen the health reforms for sustainability.

Establish NGOs

The geographic sites for establish NGOs are Semipalatinsk Urban, East Kazakhstan, Almaty, and Karaganda in Kazakhstan; Osh, Jalal-Abad, and National level in Kyrgyzstan; and Fergana, Navoi, and Syr Darya in Uzbekistan. The type of NGOs consist of PCP Associations, Community Organizations, and some Hospital Associations (HA). The ZdravReform Program will collaborate closely with Counterpart Consortium on general aspects of Establish NGOs and concentrate its resources on health related aspects of Establish NGOs. A summary for establish NGOs in these geographic sites is contained in the following table:

Country	Site	Initiate Timeframe	Roll-Out From	Type of NGO	Graduate to Mature by June 2000
KAZ	Semi Urban	Year One	Semi Rural	PCP Assoc	No
	East Kaz	Late Year One	Semi Rural	PCP Assoc	No
	Almaty	Year Two	Semi Rural	PCP Assoc	No
	Karaganda	Year Two	Zhezkazgan	PCP Assoc	No
KYR	Osh	Late Year One	Issyk-Kul	PCP/HA Assoc	No
	Jalal-Abad	Late Year One	Issyk-Kul	PCP/HA Assoc	No
	National Level	Year One	Issyk-Kul	PCP/HA/LAC	Yes
UZB	Fergana	Year One	New Uzb Model	Community Org	Yes
	Navoi	Year Two	Fergana	Community Org	No
	Syr Darya	Year Two	Fergana	Community Org	No

ZdravReform Program activities will consist of all activities necessary to establish NGOs, including the following:

1. Assess, discuss, and determine need to establish NGOs with all stakeholders.
2. Coordinate closely with Counterpart Consortium and other donors and projects to establish NGOs.

3. Evaluate and monitor the legal, regulatory, and policy environment for NGOs.
4. Provide technical assistance to develop by-laws, administrative structure, election procedures, research legal issues, and prepare registration documents.
5. Provide training and disseminate information to stakeholders on goals, vision, rights, roles, relationships, structure, strategic planning, and other organizational development activities.
6. Establish the roles and relationships between PCPs or other member groups and NGOs.
7. Assess and provide recommendations concerning the type of services the NGO could provide for their membership or their communities.
8. Provide technical assistance and operational support to NGOs to allow them to serve as a mechanism to distribute grants or humanitarian assistance.
9. Provide grants for NGOs to provide services to their members or implement community health programs.
10. Develop and implement a monitoring and evaluation system.

Strengthen NGOs

The geographic sites for strengthen NGOs are Zhezkazgan and Satpaeva Cities, and Semipalatinsk Rural in Kazakhstan; and Issyk-Kul in Kyrgyzstan. In addition, Fergana in Uzbekistan and National level in Kyrgyzstan will graduate from start-up sites to mature sites in year two.

ZdravReform Program activities will consist of all activities necessary to strengthen NGOs, including the following:

1. Provide technical assistance to strengthen legal framework and organizational structure.
2. Provide training and disseminate information to allow stakeholders to refine goals, vision, rights, roles, relationships, structure, strategic planning, and other organizational development activities.
3. Coordinate closely with Counterpart Consortium and other donors and projects to strengthen NGOs.
4. Strengthen the roles and relationships between PCPs or other member groups and NGOs.
5. Provide technical assistance and operational support to NGOs to allow them to serve as a mechanism to identify funding sources, write grants, distribute grants or request, receive and distribute humanitarian assistance.
6. Provide technical assistance and operational support to NGOs to facilitate the provision of services to their members or their communities.
7. Provide technical assistance and training to allow the NGOs to develop their capability to represent their membership in various forums or serve as advocates for various health issues.
8. Provide grants for NGOs to provide services to their members or implement community health programs.
9. Maintain and strengthen a monitoring and evaluation system.

LLR 3.2.1.1 Increased consumer choice in market based health system

The element increased consumer choice in a market based health system contributes to the result cost-effective health care services demonstrated at the oblast level by involving the population in decisions about their health care, increasing the responsibility and accountability of the population, and serving as an incentive for health providers to provide high quality, low cost health services to the population. Consumer choice is increased by the population enrolling in PCPs, and becoming more informed and more active in health care decision making. The ZdravReform Program will establish enrollment processes in start-up geographic sites to widen the health reforms, and strengthen enrollment processes in mature geographic sites to deepen the health reforms for sustainability.

Establish enrollment process

The geographic sites for establish enrollment process are Satpaeva City, Semipalatinsk Rural, and Semipalatinsk Urban in Kazakhstan; Osh, Jalal-Abad, Bishkek City, and Chui in Kyrgyzstan; and Fergana in Uzbekistan. Timing will vary, however in general enrollment activities begin following the establishment of PCPs.

ZdravReform Program activities will consist of all activities necessary to establish enrollment, including the following:

1. Provide technical assistance and training to establish a policy and legal framework for free choice of primary care provider and enrollment in PCPs.
2. Collect and analyze baseline data to assess the public's knowledge and attitudes about health care reform.
3. Identify all information channels and assess the potential to distribute information through different information channels.
4. Form and participate in Joint Working Groups and develop operational implementation plans.
5. Provide training through conferences, seminars, workshops, study tours, and exchanges to Joint Working Groups, PCPs, NGOs, health professionals, and health policy-makers concerning public awareness and marketing campaigns and enrollment.
6. Develop messages for public awareness and marketing campaigns.
7. Provide technical assistance and operational support to public awareness and marketing campaigns designed to inform and enroll the population, including developing and distributing advertisements and educational spots through media channels; newspaper articles; brochures, posters, billboards, and information sheets; promotional items; briefings at schools, employers, and other locations; and special events.
8. Prepare for operational aspects of enrollment by developing enrollment forms and database, and establishing enrollment sites and procedures for enrollment.
9. Conduct enrollment, enter enrollment data, and analyze results.
10. Develop and implement a monitoring and evaluation system.

Strengthen enrollment process

The geographic sites for strengthen enrollment process are Zhezkazgan City in Kazakhstan and Issyk-Kul in Kyrgyzstan.

ZdravReform Program activities will consist of all activities necessary for strengthen enrollment process, including the following:

1. Assess results of first marketing campaign and enrollment and attempt to raise the initial enrollment percentage to near 100%.
2. Strengthen policy and legal frameworks, Joint Working Groups, and plan development to improve sustainability of public awareness and marketing campaigns and the enrollment process.
3. Provide training through conferences, seminars, workshops, study tours, and exchanges to Joint Working Groups, PCPs, NGOs, health professionals, and health policy-makers concerning public awareness and marketing campaigns and enrollment.
4. Maintain and strengthen database, including developing a process to account for births, deaths, and migrations.
5. Analyze the population database, link it to other databases, and perform population based analyses of health services.
6. Conduct and analyze surveys of the population and health professionals to strengthen public awareness and marketing campaigns, enrollment, and other related aspects of health reform.
7. Provide technical assistance and training for all elements of ongoing public awareness and marketing campaigns and open enrollment periods.
8. Initiate public education campaigns for health reform in general, primary health care, family planning and infectious diseases using the media channels, messages, informational materials, products, and other tools developed for the initial enrollment.
9. Develop reports, products, and training materials on public awareness and marketing campaigns and enrollment primary health care to facilitate information dissemination.
10. Maintain and strengthen a monitoring and evaluation system.

LLR 3.2.1.2 Increased efficiency and accountability of health care system

Health providers are currently reimbursed based on production input measures, such as number of beds and number of staff. These provider payment systems result in excess capacity in the health sector, inefficient use of available resources, and no competition among health providers. The element increased efficiency and accountability of the health care system contributes to the result cost-effective health care services demonstrated at the oblast level by introducing new provider payment systems which contain incentives for health providers to allocate health sector resources more efficiently and create a more competitive environment in the health sector. The ZdravReform Program will establish new provider payment systems in start-up geographic sites to widen the health reforms, and strengthen new provider payment systems in mature geographic sites to deepen the health reforms for sustainability.

Establish new provider payment systems

The geographic sites for establish new provider payment systems are Zhezkazgan and Satpaeva Cities, Semipalatinsk Urban, East Kazakhstan, Almaty, Karaganda, and National level in Kazakhstan; Issyk-Kul, Bishkek City, Chui, Jalal-Abad, Osh, and National level in Kyrgyzstan; and Fergana, Navoi, and Syr Darya in Uzbekistan.

The timing of activities under establish new provider payment systems is complicated by the fact that there are actually three new provider payment systems being implemented, one for primary care practices, one for polyclinics (outpatient specialty care) and one for hospitals. Depending on the environment and the health reform objectives in each geographic site, either one, two, or all three new provider payment systems may be implemented. In general, the ZdravReform Program strategy has been to implement new provider payment systems for primary care practices and hospitals first and then based on the impact of these two payment systems to design an appropriate provider payment for the middle layer of the health delivery system, polyclinics.

The new provider payment systems may be implemented for health insurance funds, budget funds or both. In general, health insurance funds are the change agents and leaders in the implementation of new provider payment systems. Finally, there are many preconditions which must be met before new provider payment systems can be implemented effectively, including a workable institutional structure, pooling of funds, and a unified benefits package. The institutional structure issue has been particularly difficult, one of the biggest problems the ZdravReform Program has faced is the confusion and conflict between the Ministry of Health and the new Health Insurance Funds. Work continues to find a resolution for this problem and success varies across time and geographic site. Given this qualification, a summary for establish new provider payment systems in these geographic sites is contained in the following table:

Country	Site	Initiate Timeframe	Roll-Out From	Type of Payment System	Graduate to Mature by June 2000
KAZ	Zhezkazgan	Year One	Is KAZ model	PCP/ Hosp	Yes
	Semi Urban	Year Two	Semi Rural	PCP	No
	East Kaz	Year Two	Semi Rural	PCP	No
	Almaty	Year Two	Semi Rural	PCP	No
	Karaganda	Year Two	Zhezkazgan	PCP/ Hosp	No
	National Level	Year One	Zhezkazgan	PCP/ Hosp	No
KYR	Issyk-Kul	Year One	Is Kyr model	PCP/Hosp	Yes
	Bishkek City	Late Year One	Issyk-Kul	PCP/Hosp	No
	Chui	Late Year One	Issyk-Kul	PCP/Hosp	No
	Osh	Late Year One	Issyk-Kul	PCP/Hosp	No
	Jalal-Abad	Late Year One	Issyk-Kul	PCP/Hosp	No
	National Level	Year One	Issyk-Kul	PCP/Hosp	Yes
UZB	Fergana	Year One	New Uzb Model	PCP	Yes
	Navoi	Year Two	Fergana	PCP	No
	Syr Darya	Year Two	Fergana	PCP	No

ZdravReform Program activities consist of all activities necessary for establish new provider payment systems, including the following:

1. Data collection and analysis of health sector infrastructure and current financing system.
2. Development of concept and policy framework.
3. Formation and participation in Joint Working Groups.
4. Policy dialogue with national and oblast level health policy-makers.
5. Research existing laws and regulations.
6. Draft, develop, provide input to, or comment on new legal framework.
7. Develop, provide input to, or comment on operational implementation plans.
8. Provide training for all stakeholders through conferences, seminars, workshops, and meetings on health reform in general and the need to implement new provider payment systems in particular.
9. Provide or facilitate study tours and exchanges to the U.S., other countries, other parts of the region, or other demonstration sites concerning new provider payment systems.
10. Disseminate existing reports or products on new provider payment systems from mature demonstration sites to new demonstration sites.
11. On all aspects of establish new provider payment systems, collaborate with other donors or projects to provide technical assistance, training, or commodities for the development of new provider payment systems.
12. Provide technical assistance and training to establish a viable institutional structure for new provider payment systems within the health sector, including resolving the

problems surrounding the roles and relationships of the Ministry of Health and the new Health Insurance Funds.

13. Provide technical assistance and training to establish necessary preconditions for new provider payment systems, including pooling funds and unifying benefit packages.
14. Provide technical assistance and training to all aspects of the introduction of health insurance.
15. Provide technical assistance and training for macro-economic analyses, resource allocation mechanisms, benefit packages, and user fees.
16. Perform surveys to determine the health care needs of the population and the patterns of health care supply and demand.
17. Develop facility rationalization plans to reduce the over-capacity of the health sector and enable the introduction of more market-oriented provider payment systems.
18. Develop and implement a health provider Licensing and Accreditation system for health care purchasers.
19. Determine the most appropriate type of primary health care, polyclinic, and hospital payment systems for each geographic site and design the basic parameters of these three provider payment systems.
20. Perform the cost accounting and analysis of clinical information data needed to develop provider payment systems.
21. Develop all aspects of the three types of provider payment systems needed for primary health care, polyclinics, and hospitals. In general, primary care and hospital payment systems are developed and implemented first, and then polyclinic payment systems developed and implemented based on the results of the primary health care and hospital systems.
22. Analyze the current statistical forms, develop the new forms needed to support the new provider payment systems and work to avoid duplication of information in the health sector.
23. Develop, install, test, and debug information systems necessary for health purchasers to implement new provider payment systems; disseminate technical information and provide training in information systems; hire and train data entry staff; implement data collection, entry and analysis.
24. Provide computers to implement new provider payment systems.
25. Conduct "paper" tests of new provider payment systems.
26. Analyze all aspects of the existing financial flows within the health sector and develop recommendations on changes needed to implement the new provider payment systems.
27. Implement new provider payment systems.
28. Develop and implement a quality assurance system for health purchasers, including clinical indicators.
29. Develop and implement a monitoring and evaluation system.

Strengthen new provider payment systems

The geographic site for strengthen provider payment systems is Semipalatinsk Rural in Kazakhstan. In addition, Zhezkazgan in Kazakhstan; and Issyk-Kul and National level in Kyrgyzstan graduate from start-up sites to mature sites in year two. This means that each country will have at least one mature site for new provider payment systems to serve as a model for sustainability in the future.

ZdravReform Program activities consist of all activities necessary for strengthen new provider payment systems, including the following:

1. Assess strengths and weaknesses of new provider payment systems established in geographic sites.
2. Maintain policy dialogue and participation in Joint Working Groups.
3. Assess legal framework after establishment of new provider payment systems, draft, develop, provide input to, or comment on legal framework allowing institutionalization of new provider payment systems.
4. Develop operational implementation plans for strengthen provider payment systems.
5. Provide additional training for all stakeholders through conferences, seminars, workshops, and meetings on health reform in general and the need to implement new provider payment systems in particular.
6. Provide or facilitate study tours and exchanges to the U.S., other countries, other parts of the region, or other demonstration sites concerning new provider payment systems.
7. Develop reports, products, and training materials on provider payment systems to facilitate information dissemination on provider payment systems.
8. On all aspects of strengthen new provider payment systems, collaborate with other donors or projects to provide technical assistance, training, or commodities for the development of new provider payment systems.
9. Continue technical assistance and training to strengthen the institutional structure for new provider payment systems, address necessary preconditions for new provider payment systems such as pooling of funds and unifying benefit packages, and analyze macro-economic conditions, resource allocation mechanisms, benefit packages, and user fees.
10. Continue technical assistance and training to all aspects of health insurance.
11. Perform surveys to determine the health care needs of the population and the patterns of health care supply and demand.
12. Refine facility rationalization plans to reduce the over-capacity of the health sector and enable the introduction of more market-oriented provider payment systems.
13. Refine the health provider Licensing and Accreditation system for health care purchasers.
14. On new data obtained from implementation of initial new provider payment systems, perform analyses, conduct research, and document results.
15. Based on data analysis, refine all aspects of initial provider payment system to develop a strengthened, more equitable, and more sustainable provider payment system.
16. Analyze and refine all aspects of the information system supporting new provider payment systems in order to institutionalize new information flows within the health sector.

17. Provide additional computers as necessary to implement new provider payment systems.
18. Analyze the financial flows under the initial new provider payment systems, identify problems, and develop recommendations to address these problems.
19. Implement refined provider payment systems.
20. Refine the quality assurance system for health purchasers, including clinical indicators.
21. Maintain a monitoring and evaluation system.

LLR 3.2.1.6 Modern management techniques and clinical practices adopted

Health provider managers do not have adequate information for good decision-making and efficient allocation of resources. The element increased modern management techniques and clinical practices adopted contributes to the result cost-effective health care services demonstrated at the oblast level by giving health providers the tools they need to improve decision-making, adapt to the incentives of new provider payment systems, and function more like businesses. The ZdravReform Program will establish new management information systems in start-up geographic sites to widen the health reforms, and strengthen management information systems in mature geographic sites to deepen the health reforms for sustainability.

Establish new management information systems

The geographic sites for establish management information systems are Semipalatinsk Urban, East Kazakhstan, Almaty, and Karaganda in Kazakhstan; Issyk-Kul, Bishkek City, Chui, Osh, and Jalal-Abad in Kyrgyzstan; and Fergana, Navoi, and Syr Darya in Uzbekistan. The types of new management information systems are clinical information systems, financial management systems, human resource systems, quality assurance systems, rational pharmaceutical management systems, and monitoring systems for family planning and infectious diseases. Implicit in each of the different types of management information systems is the management function, or the capability of managers to adequately use the new management information systems. The geographic sites establish the types of systems which are appropriate to the environment.

Establishing management information systems is very labor intensive as the work is undertaken at the individual health provider level. Timing of the establishment of management information systems varies by site, however, in general it follows the introduction of new provider payment systems. It is a ZdravReform Program lesson learned that health providers consider new management information systems to be an intellectual curiosity until after new provider payment systems are introduced, at which point they need them and they become institutionalized more rapidly.

ZdravReform Program activities consist of all activities necessary for establish new management information systems, including the following:

1. Collect and analyze data on the type of systems health providers currently use, the inputs and outputs of current systems, and the processes used for health statistics and financial information.
2. Provide technical assistance and training to establish a policy and legal framework for management information systems.

3. Develop, provide input to, or comment on operational implementation plans to establish management information systems.
4. Provide broad training for stakeholders through conferences, seminars, workshops, and meetings on health reform in general and new management information systems in particular.
5. Provide or facilitate study tours and exchanges to the U.S., other countries, other parts of the region, or other demonstration sites concerning new management information systems.
6. Disseminate existing reports or products on new management information systems to these start-up geographic sites from mature geographic sites.
7. Collaborate with other donors or projects, including the medical partnerships program, to provide technical assistance, training, or commodities on all aspects of the development of new management information systems.
8. Automate current management information systems in order to increase productivity.
9. Perform analysis of data requirements, and based on this analysis design new management information systems.
10. Develop both manual and automated new management information systems, including forms, computer programs, databases, reports, and operating procedures.
11. Test, debug, install, and implement new management information systems.
12. Develop and distribute technical printed materials to facilitate implementation of new management information systems.
13. Coordinate information provided through the new management information systems with the new provider payment systems and health statistics requirements, including billing reports provided by health purchasers to health providers.
14. Incorporate into new management information systems monitoring systems for family planning and infectious diseases.
15. Provide technical assistance, training, and materials to support rational pharmaceutical management, including an essential drug list, development and implementation of formularies, drug information systems and materials, and logistics training.
16. Establish new health information careers such as data operators and practice managers.
17. Provide technical assistance and training to all health provider personnel, particularly practice managers, on the establishment of new management information systems.
18. Initiate collaboration with Public Health Schools, Management Schools, the Medical Academy, the Post-Graduate Institute, and the Pharmacy School to develop capacity within the health sector to educate future health managers.
19. Establish management training and resource centers by developing curriculum, compiling technical and educational materials, training trainers, and functioning as the operational base for trainers in management training networks.
20. Provide training to health managers to establish management techniques and the ability to use information produced by the new management information systems.
21. Assess hardware needs, and provide computers or facilitate their provision by other donors or projects to health providers for new management information systems.
22. Provide operational support to practice managers, data entry personnel, and other health provider personnel to initiate new management information systems.
23. Develop and implement a monitoring and evaluation system.

Strengthen new management information systems

The geographic sites for strengthen management information systems are Zhezkazgan and Satpaeva Cities and Semipalatinsk Rural in Kazakhstan. In addition, Issyk-Kul in Kyrgyzstan will graduate from a start-up site to a mature site in year two.

ZdravReform Program activities consist of all activities necessary for strengthen new management information systems, including the following:

1. Assess strengths and weaknesses of new management information systems established in geographic sites.
2. Assess legal and policy framework after establishment of new management information systems, provide additional technical assistance and training as necessary to allow institutionalization of a legal and policy framework for new management information systems.
3. Develop operational implementation plans to strengthen management information systems.
4. Provide additional broad training for all stakeholders through conferences, seminars, workshops, and meetings on health reform in general and management information systems in particular.
5. Provide or facilitate study tours and exchanges to the U.S., other countries, other parts of the region, or other demonstration sites concerning new management information systems.
6. Develop reports, products, and training materials on management information systems and disseminate them to start-up geographic sites.
7. Continue to collaborate with other donors or projects, including the medical partnerships program, to provide technical assistance, training, or commodities on all aspects of the development of new management information systems.
8. Assess the types of new management information systems established, analyze the appropriateness of information they produce and how the information is used by management, and identify problems with the new management information systems.
9. Based on the assessment of new management information systems established, refine and implement strengthened management information systems, including monitoring systems for family planning and infectious diseases.
10. Use the data and reports generated by the new management information systems to perform analysis and conduct research on health services.
11. Develop and distribute technical printed materials to facilitate implementation of refined management information systems.
12. Continue to coordinate information provided through the new management information systems with the new provider payment systems and health statistics requirements, including billing reports provided by health purchasers to health providers.
13. Refine technical assistance, training, and materials to support rational pharmaceutical management, including an essential drug list, development and implementation of formularies, drug information systems and materials, and logistics training.
14. Continue to provide technical assistance and training to all health provider personnel, particularly practice managers, on the implementation of new management information systems.

15. Continue to collaborate with Public Health Schools, Management Schools, the Medical Academy, the Post-Graduate Institute, and the Pharmacy School to develop capacity within the health sector to educate future health managers.
16. Expand management training and resource centers and the network of trainers.
17. Continue to provide management training to health managers to strengthen management techniques and the ability to use information produced by the new management information systems.
18. Assess hardware capacity, and provide additional computers as necessary or facilitate their provision by other donors or projects to health providers for new management information systems.
19. Provide operational support to practice managers, data entry personnel, and other health provider personnel to strengthen new management information systems.
20. Maintain and strengthen the monitoring and evaluation system.

IR 3.2.3 Cost-effective health reforms adopted nationally

Cost-effective health reforms adopted nationally is the second of two USAID ZdravReform Program results. There are two aspects of national level program activities. First is work at the national level required to facilitate oblast level demonstrations. Second is work at the national level required to institutionalize the results of oblast level demonstrations. Elements of cost-effective health reforms adopted nationally are legal, regulatory, and policy framework, information dissemination, and donor collaboration. These elements are described below.

LLR 3.2.3.2 National legal, regulatory, and policy framework established

The element national, legal, and policy framework contributes to the result cost-effective health sector reforms adopted nationally by first facilitating the implementation of oblast level reforms and then institutionalizing oblast level reforms by incorporating them into a long-term national legal, regulatory, and policy framework.

The geographic sites for national legal, regulatory, and policy framework established are Almaty, Kazakhstan, Bishkek, Kyrgyzstan, and Tashkent, Uzbekistan. Some of the focus for national level work in Kazakhstan will move from Almaty to the new capital of Astana, exactly how much and interaction with which counterparts is not yet clear.

ZdravReform Program activities consist of all activities necessary for national legal, regulatory, and policy framework established, including the following:

1. Monitor and assess the national policy environment concerning all aspects of health reform.
2. Create and adapt mechanisms and processes for policy dialogue such as formation and participation in Joint Working Groups undertaking policy development.
3. Develop conceptual and policy frameworks and engage in policy dialogue with all stakeholders including but not limited to the Ministry of Health, Health Insurance Fund, Sanitary and Epidemiological Service, Ministry of Finance, Social Insurance Fund, the Government, Strategic Planning Agencies, and Parliament.
4. Respond to requests from counterparts for policy analysis.

5. Coordinate national policy and oblast level activities.
6. Monitor and produce assessments of program risks due to changes in Government structure, new counterparts, or other unforeseen events.
7. Gather, translate, review, assess, monitor, and engage in dialogue concerning all aspects of the health reform legal framework and relevant laws and regulations.
8. Draft, provide input to, or comment on laws and regulations.
9. Provide technical assistance and training for health care decision-makers and other stakeholders on policy and legal issues.
10. Perform assessments, engage in policy dialogue, planning, and other limited technical assistance and training in geographic sites not included in the oblast level result, for example, Pavlodar, as requested by USAID or national counterparts.
11. Monitor the regional policy and legal environment and engage in regional dialogue to extend good policies or avoid problems, for example, extend lessons learned concerning the implementation of health insurance to Uzbekistan.

LLR 3.2.3.1 Project products disseminated and public awareness raised

The element project products disseminated and public awareness raised contributes to the result cost-effective health sector reforms adopted nationally by disseminating project products to health professionals and health policy-makers to inform them and extend oblast level health reforms and making the public aware of the impact of health reforms and health promotion activities.

Although information dissemination activities extend across all geographic sites, activities will be initiated and managed from Almaty, Kazakhstan; Bishkek, Kyrgyzstan; and Tashkent, Uzbekistan.

ZdravReform Program activities consist of all activities necessary for project products disseminated and public awareness raised, including the following:

1. Prepare research materials, papers, case studies, and lessons learned related to health reform for dissemination regionally, in the NIS, and internationally.
2. Manage marketing teams in different sites to ensure coordination of information dissemination activities across the region, also identify resources within the region which can be utilized to disseminate materials and products.
3. Perform surveys and focus groups as necessary to assess the knowledge, acceptance, and satisfaction of the population and health professionals concerning health reform.
4. Develop conceptual framework, determine audiences, assess media channels, develop health reform messages, and develop plans for public awareness campaigns.
5. Develop and implement public awareness campaigns for health reform and health insurance using a variety of types of materials and distribution channels.
6. Develop and implement a health promotion campaign consisting of videos and other health promotion materials in collaboration with Counterpart Consortium and the Center for Healthy Lifestyles or its equivalent.
7. Perform internally, retain, or coordinate with press clubs or other organizations with access to journalists to ensure that materials are obtained by the media, distributed, and breadth of dissemination monitored.
8. Provide training for journalists on health reform topics.

9. Move the ZdravReform library from Russia, Ukraine, and Bethesda to Almaty.
10. Inventory and organize the consolidated library to begin development of materials for dissemination, also identify gaps in materials available.
11. Compile, edit, and consolidate reports, seminars, presentations, and other materials or products into a standard format conducive for dissemination to a wider audience.
12. Write, develop or otherwise obtain materials or products to be disseminated to counterparts.
13. Reproduce and distribute materials and products for counterparts using a variety of mechanisms.
14. Coordinate these materials with training materials available from resource centers developed under management information systems.
15. Coordinate dissemination of materials and products from mature geographic sites to new geographic sites.

LLR 3.2.3.3 Increased adoption of successful demonstration interventions in other oblasts

Donor and project collaboration has been a priority of the ZdravReform Program since its inception, it will remain a priority. Increased adoption of successful demonstration interventions in other oblasts contributes to the result cost-effective health sector reforms adopted nationally by leveraging USAID resources to extend health reforms to other oblasts or nationwide, and ensuring that health reforms implemented by other donors or projects are consistent with the USAID ZdravReform Program model.

Although donor and project collaboration activities extend across all geographic sites, activities will be initiated and managed from Almaty, Kazakhstan; Bishkek, Kyrgyzstan; and Tashkent, Uzbekistan.

ZdravReform Program activities consist of all activities necessary for increased adoption of successful demonstration interventions in other oblasts, including the following:

1. Coordinate and collaborate closely with the World Bank and Asian Development Bank (ADB) on current and future health related projects, including providing technical assistance and training to World Bank or ADB geographic sites to maximize the impact of ZdravReform Program health reforms, positively leverage USAID resources, and roll-out USAID programs.
2. Participate in World Bank or ADB missions and conferences to design, develop, or disseminate health related projects.
3. Continually meet, interact, coordinate, and collaborate with other relevant USAID funded programs, including the medical partnerships program, SOMARC, CDC, Basics, AED, IESC, Counterpart Consortium, Office of Social Transition Local Government Program, Legal Programs, and Office of Market Transition Programs on health, social sector, or budgetary issues,
4. Continually meet, interact, coordinate, and collaborate with other donors or projects with Central Asian programs in health care or related social sector areas. Donors or projects include but are not limited to the British Know How Fund on rationalization and primary health care, GTZ on health insurance, WHO on all programs, International Labor Organization on macro-economic and labor market issues, all other UN specialized agencies on all relevant activities, CHAP to

channel humanitarian assistance to NGOs and PCPs, Peace Corps to place volunteers in ZdravReform Program geographic sites, STLI for clinical training, Mercy Corp for grants to NGOs and PCPs, Soros Foundation for grants to NGOs and PCPs,

5. Family planning collaboration with reproductive health agencies includes IPPF, UNFPA, and SOMARC, and infectious disease collaborations include Basics on ARI/CDD, Project HOPE and CDC on TB, the University of Wisconsin on STDs, WHO, UNICEF, UNESCO, and UNAIDS.

Regional Activities

The budget includes funds for counterparts to participate in selected seminars and other types of training throughout the NIS. In addition, as funds become available, the ZdravReform Program will conduct limited regional activities, for example, sponsoring conferences and distributing materials.

Management Functions

The final ZdravReform Program element is Management Functions. Obviously, there are many management functions contained in the ZdravReform results framework outlined above. Only activities which can't be tied directly to an element are included in the element Management Functions. The principal ZdravReform Program activities for this element are site start-up, site shut-down, and USAID liaison activities not directly related to a program result.

Appendix A
Background Information on the USAID ZdravReform Program

A. Introduction

The USAID funded ZdravReform Program has been operational in Central Asia since June 1994, when the regional office in Almaty was established. During the last four years it has developed a strong program in Kazakhstan and Kyrgyzstan, and in 1997 a program was commenced in Uzbekistan. The program was designed to address three fundamental problems in the health sector:

1) Reduced availability and high cost of pharmaceuticals;
2) Inefficient use of available resources and lack of incentives to improve productivity; and
3) Decreased level of funding.

The principal program strategy has been to work intensively in selected oblasts in all three countries to comprehensively restructure the health system, and to work at the national level to create the regulatory framework to support reforms.

To address the problem of reduced availability and high cost of pharmaceuticals, USAID's ZdravReform Program plan was to improve the system of pharmaceutical distribution in Kazakhstan through privatization. The components of the pharmaceutical

privatization program were privatization of retail and wholesale pharmacies post-privatization support of pharmacies to increase their capacities as businesses

In terms of inefficiency, USAID's ZdravReform Program plan has been to shift resources from the hospital sector to a reorganized system of primary care consisting of independent primary care practices. The new primary care practices have been strengthened clinically, organizationally, and financially. The population has been provided with opportunities to exercise free choice of primary care provider through a process of open enrollment. This creates incentives for the primary care practices to provide higher quality, lower cost services to retain their enrollees. Rationalization of health facilities has created savings by reducing the capacity in the health sector, and encouraging the formation of general hospitals.

The introduction of new provider payment systems has been intended to promote competition, rationalized fixed capacity in the health sector, shift resources to primary care, and decrease referrals to specialists and hospitals. Hospitals are to be reimbursed by a case-based payment system in order to generate competition and create the conditions necessary for downsizing of the hospital sector, resulting in increased resources being devoted to primary care. New outpatient payment systems ranging from partial capitation for primary health care to an outpatient specialist and diagnostic test fee schedule, to full fundholding, have been intended to provide financial incentives to shift resources from inpatient to outpatient services.

New provider payment systems require new infrastructure in the health sector, for example, computerized billing systems for purchasers of health services. New management information systems for health providers will provide the tools needed to allow health providers to adapt to the incentives of the new provider payment systems, and make decisions which improve health sector efficiency.

In terms of financing, USAID's ZdravReform Program plan has been to create a single payer system, a health insurance fund, which pools all health funds (including employer premiums) for the oblast. This institutional structure is necessary for the introduction of new incentive-based payment methods. In addition, activities encompassing the collection of employer funds, the institution of user fees, determination of a minimum benefits package, and addressing macro resource allocation issues, have been intended to diversify health care sector funding sources, and allocate existing resources effectively.

B. Historical Environment

The legacy of the Soviet system and the transition to a market-based economy have had dramatic consequences for the health sector in Central Asia. Resources available to maintain the health care system have declined steadily since the 1980s, with health care expenditures as a percentage of gross domestic product (GDP) declining from about 6 percent in the 1980s to less than 3 percent in 1996. In addition, GDP has continued to fall over that period throughout the region, resulting in a significant reduction of real per capita health expenditure.

The declining health sector resource base cannot sustain the current service infrastructure. Because facilities historically received their funding based on a

combination of capacity and utilization rates, there was an incentive to maintain large, inefficiently utilized physical structures and medical staff, high hospital admission rates, long hospital stays, and excess bed capacity.

Inefficient allocation of resources was also observed in the strong bias for curative over primary health care, with hospitals consuming about 70 percent of the health sector budget, and primary care providers constituting fewer than 20 percent of all physicians. Primary care physicians are poorly paid and lack proper equipment and supplies, encouraging high referral rates to specialists and more expensive inpatient facilities. The inadequate financing and under-utilization of the primary care sector was particularly acute in rural areas. Despite a well developed network of primary care facilities, continued lack of financing and overemphasis on rural hospitals has led to the deterioration of the primary care sector.

The crisis in the health care system was also evident in the pharmaceutical sector. The amount and range of available drugs declined, while prices rose steadily, rendering many basic medicines inaccessible to large segments of the population. Introducing competition into the pharmaceutical sector was essential for improving the availability and reducing the prices of drugs.

The national introduction of health insurance in Kazakhstan and Kyrgyzstan reflected consensus among policymakers and health care providers to engage in dramatic reform of the health care financing and service delivery systems. It also created the opportunity to introduce incentive-based payment methods, and to shift the delivery system's emphasis to primary care and more appropriate, higher quality curative care.

C. Technical Approach to the Implementation of the Reforms

USAID's ZdravReform Program resources are currently concentrated in oblasts with demonstrated commitment to health reform, focusing on the following program areas:

1. Restructuring service delivery by strengthening the primary care sector;
2. Increasing population participation in decisions about their health care;
3. Designing and implementing incentive-based provider payment systems, including implementing health insurance and addressing health sector institutional structure; and
4. Creating new health provider level management information systems to improve decision-making.

1. Restructuring Service Delivery

One of the most profound inefficiencies in the health care system is the imbalance between the hospital and primary care sectors. As mentioned above, financial and human resources are concentrated in the hospital sector. In addition, the organization and administration of service delivery was formerly heavily biased toward centralized command and control. Clinical and management decisions were not based on health outcomes-based standards, but rather on legalistic targets, quotas and static norms of treatment.

The health systems in the former Soviet Union can be likened to an inverted pyramid: Most of the resources go to the hospital sector and to polyclinics, to support massive levels of brick and mortar and employment of too many physicians, with only limited funding available to the primary care sector. Massive and underutilized buildings housing an oversupply of physicians could be replaced by smaller group or solo practices providing better primary health care services.

There are also clinical obstacles to the development of the primary care sector. Training of primary care physicians, by Western standards, is inadequate, and thus conditions that should be effectively treated in the primary care sector are treated in the hospital or by specialists at polyclinics. For fear of reprisal or alienation, physicians strictly follow prekazes, or legal mandates for treatment and referral set at the national level.

A major objective of USAID's ZdravReform Program is to completely restructure the system of primary care in urban and rural areas. In urban areas, this means creating new organizational units, or Primary Care Practices (PCPs), preferably located in the community. PCPs consist of therapists (internists), pediatricians, gynecologists, nurses, and a practice manager, and can receive some variation of per capita payment based on the number of patients they enroll in their practice. In rural areas, the PCPs would consist of converted SVAs (rural ambulatory clinics) and FAPs (feldsher-midwife points).

Clinical training is an essential element of restructuring service delivery. Restructuring the primary care sector is not enough, the way medicine is practiced must also change. Clinical training should emphasize family medicine skills and provision of care in a community setting.

Another important element of restructuring service delivery is the creation of new NGOs in the health sector. NGOs such as Family Group Practice Associations allow the new PCPs to obtain support in their efforts to function as independent business entities and provide them with a representative voice in policy-making.

Finally, the integration of family planning and infectious diseases is a critical element of restructuring service delivery. Primary health care is the appropriate level of service for family planning and prevention and treatment of many infectious diseases. In order to integrate family planning and infectious diseases into primary health care, a strong primary health care system must first exist. USAID's ZdravReform Program strategy is to first restructure the delivery system to strengthen primary health care and then convert family planning and infectious disease services from vertical, stand alone programs to integrated primary health care services.

2. Consumer Participation in Health Care

USAID's ZdravReform Program is focused on defining a stronger role for consumers. The Program's goals are: 1) to increase consumer participation in health care decision-making through public awareness campaigns; 2) to create a constituency among providers and the public for health reform in general; 3) to inform the public about changes occurring through health care reform particularly restructuring of primary

health and the concept of free choice of provider; and 4) to encourage voluntary enrollment in primary care practices.

The rationale for USAID's ZdravReform Program involvement in activities to increase consumer participation in health care is three-fold. 1) Informed consumers are more likely to become active consumers who hold providers accountable and thus play a role in improving the quality and efficiency of health care; 2) Introduction of consumer choice is closely tied to the reorganization of the primary care system; and, 3) Increased power in decision making about health care can contribute to the desire for more democratic participation in other aspects of life.

3. Provider Payment Systems

The allocation of health resources in Central Asia has followed the traditional Soviet chapter budgeting process, allocating health funds across facilities by input measures, such as the number of beds, rather than by the quantity and quality of services delivered. The budgets were disbursed by budget chapters according to strict norms. Since budgets were required to be spent according to chapter allocations, facilities could not use their resources most cost-effectively. Provider payment reforms currently underway in Kazakhstan and Kyrgyzstan focus on introducing competition among health providers by moving from centrally planned budgets to payment for services provided, and allowing facilities greater control over the utilization of their resources.

By separating financing from services provided, the historical budgeting process obscured the costs of health services. In designing and developing the new provider payment systems, the first step is determining the true costs of health care services. USAID's ZdravReform Program has developed a cost accounting system that bridges the old 18-category budget and accounting systems with more modern methods of cost calculation and analysis. The new system utilizes a simplified step-down and costing approach, based on the US Medicare program's experience.

For new hospital payment methods, the cost accounting system is used to calculate the average cost per case in each clinical department in each hospital. Clinical groups are developed which differentiate and classify diagnoses by type and severity of illness, and, therefore, by level of resources required for treatment. Costs are then applied to each clinical group and then converted into relative weights, which, combined with an estimate of the total pool of funds available for inpatient care and calculation of a base rate, yield prices per case for each clinical group.

In practice, payment reforms can vary in complexity and sophistication, beginning with the payment of a simple facility-specific average cost per treated case, to much more sophisticated clinical group reimbursement schemes. Even simplified case-based payment systems represent a symbolic movement toward market-oriented financing, which, given the health sector's current administrative and technical capacity, is an important short-term result. In addition, implementation generates the data required to further refine the payment system.

The new case-based hospital payment systems allow hospitals to compete fairly because stable prices are paid for well-defined units of output. Once these systems are fully implemented, facilities will be able to plan their services, increasing the capacity

of efficient departments and downsizing or closing departments with average costs higher than the payment levels.

Outpatient payment reforms have the dual goals of introducing incentives to increase the productivity of primary care providers and reducing inappropriate referrals to specialists and hospitals. The payment reforms also support the restructuring of outpatient care to more family-oriented service delivery, with a reduced, but more independent, role for specialists. To achieve these objectives, USAID's ZdravReform Program has adopted a combined strategy of assisting in the establishment of primary care practices, and developing outpatient payment systems that lead to progressively more control of resources by primary care practitioners.

Outpatient payment reforms may lead to a system of "fundholding," in which family practitioners receive a capitated payment for the complete health care of each patient and purchase outpatient specialty and hospital care as needed. This payment system, complemented by free provider choice, financially rewards primary care physicians for higher activity levels and reductions in inappropriate referrals to hospitals. Paying for health care through fundholding introduces competition into the entire system, encourages physicians to become cost-conscious purchasers and suppliers of health services, and increases the prominence of primary care.

A mechanism facilitating the introduction of new provider payment systems in Central Asia has been the introduction of health insurance. Health insurance allows the health sector to diversify sources of funding for health care and the organizational structure and capacity necessary to introduce incentive-based payment methods. It is important that institutional structure issues such as clear definition of the roles and relationships between the Ministry of Health and the new Health Insurance Fund are resolved in order to maintain a single payer for health services.

Finally, the introduction of new provider payment systems requires a huge investment in the development of information systems to administer the new provider payment systems and provide the information needed to make good policy choices related to health.

4. Management Information Systems

Health management information systems at the provider level are required to give health providers the tools they need to improve decision-making and adapt to the incentives of the new provider payment systems.

In the former Soviet Union, health providers collected enormous amounts of information on health sector budgets, service utilization, and health status indicators. The data, however, were not compiled in a way that facilitated analysis, and it was difficult to link costs with utilization or health outcomes. While a large investment in management information systems at the provider level may not make sense for the health reforms of many developing countries, since the capacity already exists in the former Soviet Union it is very appropriate to re-channel this capacity in a way that allows better decision-making.

Health providers need to function more like businesses. Hospitals must understand the costs of producing their services and develop plans to reduce costs and increase revenues. Primary care providers must be concerned about the health of their practices as well as that of their patients, and they must market themselves to the users and purchasers of health care. USAID's ZdravReform Program's approach is to build the capacity of health professionals by introducing management systems tools that can be applied in a market-based health care system, and to develop a new cadre of health care management professionals.

Management information systems consist of clinical information systems, financial management systems, quality assurance systems, and rational pharmaceutical management. New management information systems will facilitate the integration of family planning and infectious diseases into primary health care. With these tools, data analysis can be integrated as a routine component of health policy and management decision making. Of course, inherent in management information systems is increased management skills for managers of health providers, including the ability to use effectively additional information.

The introduction of modern clinical practices and systems of quality assurance is a important element. USAID's ZdravReform Program has encouraged movement away from quality control toward principles of continuous quality improvement. Quality management is important to ensure that any perverse incentives of the new provider payment systems do not result in inappropriate levels of health services. Finally, licensing and accreditation of health providers is necessary to establish objective standards for health providers.

The four program elements discussed above represent the core of USAID's ZdravReform Program. Implementation of the core health reforms requires a strong supporting cast. The characters in this supporting cast are policy/legal framework, information dissemination, collaboration with other donors, and monitoring and evaluation. These functions are normally implemented at the national level in order to support core health reform activities which normally occur at the oblast level.

The purpose of grants and commodities is to provide products to facilitate and multiply the impact of health reforms undertaken in Central Asia demonstration oblasts. Allocation of the grants or commodities will be largely restricted to oblasts with USAID ZdravReform Program activities. The majority of funding for grants or commodities will be used to provide equipment to facilitate primary care restructuring and improve the capacity to provide family planning or infectious disease services, provider computers to enhance institutional capacity to implement new provider payment systems or management information systems. Limited renovations for primary care practices may also be provided. The mechanism and process for providing these commodities vital to the implementation of health reforms will be reassessed.

USAID's ZdravReform Program is summarized in the chart entitled Health Reform Model. The natural logic of the chart is to start from the outside circle and move in. This is not an effective way to do health reform in the former Soviet Union. If the national policy/legal framework is finalized before restructuring health service delivery, changing the way medicine is practiced, and changing the way providers are paid, the result is further institutionalization of the old system. The USAID's

ZdravReform Program approach is to begin in the inside circle, accomplish significant health reform and then use initial results to extend the reforms through development of a new policy/legal framework and dissemination of results.

D. 1996 Evaluation of the Central Asian ZdravReform Program

In September 1996, an evaluation was carried out of USAID's ZdravReform Program in Central Asia, Russia, and the Ukraine. The evaluation found that "the project is making a major contribution to the achievement of Central Asia's and ENI's strategic objectives" and that "the project is meeting or exceeding the targets outlined in the annual workplans."

One of the principal findings was support for "the rolling design" of the project. As the report explains, "because of site-specific problem analysis and the ability to tailor the design of local project interventions, the intensive demonstration sites have been able to target the issues most relevant to the reform of the financing system and the organization of health care delivery." The evaluation suggested that it is important to design the project option with sufficient flexibility to change activities based on the commitment to reform.

The evaluation team suggested that in the extension more emphasis should be placed on national level activities. To support reforms in the oblasts more intensive work with the national level authorities should be undertaken. In addition, the extension should place more emphasis on the dissemination of the experience from the intensive demonstration sites. This would be useful not only for national level authorities but for other oblasts.

The other findings from the evaluation cover a range of topics. In terms of payment systems, the evaluators were very positive. For hospital and primary care provider payment, the evaluators suggested that additional technical assistance is needed to continue to make the new payment systems operational. They also pointed out that more work was needed to develop an appropriate risk-sharing arrangement between the payer and the primary care practices under full fundholding.

In terms of the clinical issues, the evaluators argued that more emphasis should be placed on developing clinical training. The evaluators realized that extensive work in this area was beyond the scope of USAID's ZdravReform Program and that USAID should consider more extensive work in this area either through its ZdravReform Program or through other contract vehicles. The project should continue to work on clinical training of primary care physicians and nurses and should provide basic equipment, upgrade laboratories, and develop drug formularies.

The evaluators suggested that more work should be placed on introducing modern methods of quality improvement. They suggested the development of a set of good practice parameters using the new medical information systems that have been developed. This will require more extensive computerization in some of the demonstration oblasts.

E. Lessons Learned

The lessons learned are outlined below and concentrate on those impacting the overall program administration and strategy.

The basic strategy of USAID's ZdravReform Program has been to work intensively in selected areas which were called Intensive Demonstration Sites (IDS). Initially, one site was selected for Kazakhstan and one for Kyrgyzstan. In 1997 agreement was reached with the Government of Uzbekistan on the selection of an IDS in three rayons of Fergana Oblast.

The IDS strategy has been critical to the success of the project. It has provided a unique opportunity to actually restructure the health system and learn from the experience. This concrete experience has been used to influence national policy based on actually implementing reforms rather than theoretical models. The success of the program can largely be attributed to "learning by doing" and this on-going experience is a critical component for developing realistic national policies for reform of the health sector.

Experience has shown that the IDS strategy has high risks, but also great potential for success. In the case of Issyk-Kul Oblast, Kyrgyzstan, the IDS has been successful because of the size and geography of the country, the status of existing health reforms in the country, and support by the national and oblast governments. The key ingredient has been a strong leader in the Oblast Health Department (OHD) who feels a sense of ownership for the reforms and is willing and able to carry out them out in the face of local and national opposition.

In the case of South Kazakhstan Oblast, Kazakhstan, the conditions required for success were never met. There was weak leadership in the OHD and political struggles between the OHD, the Shymkent City Health Department, the Oblast Government, and the Health Insurance Fund. Inadvertently, the program became enmeshed in political struggles between the various organizations that were competing for control of the health reform process.

The creation of local offices in an IDS makes it difficult to respond to a rapidly changing environment. In South Kazakhstan, a local office was established with ex-patriate advisors and local staff before there were sufficient reforms to justify such an investment. Once established the local office has a vested interest in continuing their activities even if the political situation is not conducive to reform. In retrospect, it is better to begin with much more limited resources in the IDS sites until it is clear that the reform process requires an ex-patriate advisor. In the case of South Kazakhstan, it was apparent after six months that the intensive reforms were not possible and the IDS was closed. In Issyk-Kul Oblast, a local office was established, but an ex-patriate advisor was not placed until six months into the project when it was clear that the reforms were sufficient to justify it. The work of the IDS is continuing there after the resident adviser completed his two year assignment in June 1997.

Early in 1996, the strategy in Kazakhstan changed from an IDS strategy to a strategy where USAID's ZdravReform Program provided technical assistance from the Regional Office to selected oblasts who had already demonstrated a commitment to undertake health reforms. Significant reforms supported by USAID's ZdravReform Program are now underway in Zhezkazgan (merged into Karaganda Oblast in May 1997) and Semipalatinsk (merged into East Kazakhstan Oblast in May 1997), supported by local staff in the oblast, and technical assistance provided by ex-patriate and local staff in the regional office. This is a better strategy because it provides greater

flexibility to respond to the changing political environment. However, it is critical to continue reforms in demonstration sites to continue the learning process and determine what is appropriate for national reforms.

An additional lesson learned from the IDS strategy is that there is need for strong support by the local oblast government coupled with strong national support. In the case of Issyk-Kul, USAID's ZdravReform Program was able to develop a strong constituency for reform in the oblast. However, as the program did not have an office in Bishkek, the concept and results of health reforms in Issyk-Kul were not adequately communicated to the national level and the national level did not feel proprietary about the demonstration.

The establishment of office in Bishkek in early 1997 has provided USAID's ZdravReform Program with a much greater level of interaction with the National Ministry of Health (MOH) and Health Insurance Fund (HIF). On-going interaction with these national level agencies is required to cultivate understanding and support for health reforms and to institutionalize the results of the demonstration. It was also learned that sometimes it requires a catalytic event such as the MOH and HIF institutional structure crisis and the creation of the MOH and HIF jointly used systems to forge stronger relationships between the national level and the oblast health reforms. This catalytic event resulted in the institutionalization of the health reforms through a national health reform strategy.

In Uzbekistan, this problem was avoided by establishing offices in both Tashkent and the demonstration site, Fergana Oblast. USAID's ZdravReform Program has taken pains to ensure that the national level is aware and approving the health reforms at every step. Of course, this process can at times be taken too far, because it is often the initiative and progressive thinking at the oblast level that triggers the health reforms. Clearly, a delicate balance must be maintained between the national and oblast level.

Another lesson learned by USAID's ZdravReform Program is the need for strong technical assistance in implementation. We have learned that it is not sufficient to design a new payment system. For the reforms to work, there is need for sustained technical assistance on all operational procedure issues such as the development of billing forms, support for data entry, and so on. Therefore, it is important to have a strong presence in the oblasts where the critical reforms are occurring. This support can be provided cost effectively by trained local staff who are not constrained by language and cultural barriers. It is not possible for ex-patriate advisors to carry out the majority of work. There are too many activities in too many places. Given sufficient training local staff can become critical implementers of reform.

A final lesson is the need for commodities to support the reform process. The health system is critically under-funded and there is not even limited capital funds to start the reforms. The reorganization of polyclinics into family group practices requires financial resources to purchase medical equipment, textbooks, and to carry out renovations. The introduction of new payment systems requires computers. Limited capital input is needed to successfully initiate the health reforms, and then intermittent capital investment is needed to strengthen the reforms, for example additional computers.

F. Staffing

After almost four years of operation, USAID's ZdravReform Program is a mature project and its staffing needs have been clarified and expanded since the initial contract. Originally, the contract envisioned a small core of ex-patriate staff primarily responsible for administration and program management, while the technical work would be carried out by short-term consultants. This strategy proved not to be effective in the context of Central Asia particularly with Intensive Demonstration Sites (IDS).

The need for resident advisors in the IDSs, who could provide on-going technical assistance, was identified and largely met. In Kazakhstan and Kyrgyzstan this has subsequently evolved to the next phase whereby sustained technical assistance is now provided by trained local staff who are managed from the regional office in Almaty or from offices in the capital cities such as Bishkek. The appointment of a resident adviser for Uzbekistan is still relevant due to the program being in an initial phase and also due to the geographic distance involved in traveling there.

Another strategy was to develop a cadre of international consultants who were familiar with the project and could carry out on-going technical assistance activities in conjunction with the ex-patriate staff and local staff. These consultants have been informally termed "long-term, short-term" consultants. This core set of consultants are committed to working on the project on an on-going basis; they work in multiple sites; and they operate independently.

Over the four year period, local staff have been developed who can provide on-going technical assistance and implement many of the program activities. This is very apparent in the development of computer systems to support incentive-based payment reforms. Local staff have developed and can implement clinical training programs, FGP and polyclinic architectural designs for renovations, marketing campaigns, management systems, clinical information systems, quality assurance systems, drug formularies, public health programs, and so on with limited input from ex-patriate staff. In addition, local staff have been trained to take over many of the administrative responsibilities, particularly logistics and office accounting, with limited supervision from ex-patriate staff.